



eSDR

Department of Mental Retardation eSDR Signature Authorization Form

(to be submitted to any DMR Regional Office)

Provider Name: _____

FEIN: _____

The individual(s) identified below are authorized to sign the “**Vendor Certification**” on Payment Vouchers (PV’s) and Service Deliver Reports (SDR’s) for contracts between this agency and the Department of Mental Retardation. **I understand that the individual(s) will be assigned a user ID by DMR that will authorize him or her to submit the electronic equivalent of such documents.**

Last Name	First Name	Title	e-mail address*	Phone #	Designee Original Signature	Code**

*the individual must have their own e-mail address. A corporate electronic mail box is not sufficient. He or she will receive confirmation of their user ID at this address.

**Code: Note whether this request is for a “C” for Change or “A” for Add or “D” for Delete (does not require individual’s signature)

Requested must be signed by an Authorized Signatory of the Provider

Name (please print)

Title

Signature

Date

Signature Verified: _____

DMR Regional Office

Date